Intake Questionnaire

Name:
Date Of Birth:
Date:
Gender:
Gender Pronoun:
Sexual Orientation:

Presenting Problems and Concerns

Describe the problem that brought you here today:

_____

_____

When did it start and how does it affect you?

_____

_____

Estimate the severity of the above problem:

☐Mild ☐Moderate ☐Severe ☐Very Severe

Please check all the behaviors and symptoms that you consider problematic:

☐Impulsivity
☐Distractibility
☐Hyperactivity
☐Boredom
☐Poor memory
☐Phobias
☐Compulsive behaviors
☐Hopelessness
☐Self-harm behaviors
☐Guilt/Shame
☐Eating problems
☐Computer Addiction
☐Parenting Problems
☐Homicidal Thoughts
☐Relationship problems
☐Visual hallucinations
☐Hearing voices

☐Change of appetite
☐Lack of motivation
☐Isolation
☐Mood Swings
☐Panic attacks
☐Obsessive thoughts
☐Sadness/Depression
☐Helplessness
☐Loneliness
☐Fatigue
☐Gambling problems
☐Aggression/Fights
☐Problems with pornography
☐Irritability/Anger
☐Flashbacks
☐Work/School problems
☐Sexual Problems

☐ Paranoia
☐Racing thoughts
☐ Too much energy
☐Anxiety/Worry
☐Social discomfort
☐Sleep problems
☐Loss of pleasure
☐Thoughts of death
☐Low self-esteem
☐Nightmares
☐Alcohol/Drug
☐Other Concerns
_____

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Are your problems affecting any of the following?

□ Hygiene	□Housing	□Legal matters
□Finances	□Recreational Activities	□Sexual activity
□Health	□Everyday tasks/functioning	□Health
□Housing	□Self-Esteem	

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Have you ever had thoughts, made statements, or attempted to hurt yourself? ☐YES ☐ NO If yes, please describe:

_____

Have you ever had thoughts, made statements, or attempted to hurt someone else? ☐YES, ☐NO If yes, please describe:

_____

Family and Developmental History

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/Partner			
Children			

Family Mental Health Problems	Who?
Depression	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Eating Disorders/Disordered Eating	
Hyperactivity	
Sexually Abused	
Bipolar	
Anger/Abusive	
Alcohol Abuse	
Substance Abuse	

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Schizophrenia	
Completed Suicide	
Psychiatric Hospitalizations	

☐Parents legally married or living together
☐Parents temporarily separated
☐Mother remarried: # of times _
☐Father remarried: # of times _

Please check if you have experienced any of the following types of trauma or loss:

☐Emotional abuse
☐Sexual abuse
☐Physical Abuse
☐Parent substance abuse
☐Financial problems
☐Neglect
☐Violence in the home
☐Crime Victim
☐Parent Illness
☐Lived in a foster home
☐Multiple family homes
☐Homelessness
☐Loss of a loved one

Past/Present Psychotherapy (specify: month years (beginning to end), estimated number of sessions, initial reason for therapy and how helpful it was and why it ended:

1)_____
_____
_____
_____
_____

2)_____
_____
_____
_____
_____

3)_____
_____
_____
_____
_____

Medical Information

Name of Primary Care Physician: _____
Date of last physical exam: _____
Have you experienced any of the following medical conditions during your lifetime?

☐Allergies
☐Chronic Pain
☐Dizziness/Fainting
☐Asthma
☐Surgery
☐Meningitis
☐Headaches
☐Serious Accident
☐Seizures
☐Stomach aches
☐Head Injury
☐Visions Problems

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☐High Fevers	☐Diabetes	☐Hearing Problems	☐Miscarriage
☐STD	☐ Abortion	☐Sleep Disorder	☐High blood Pressure
☐Heart Problems	☐Kidney Failure	☐TBI	☐Other (list below)

_____

Please list any CURRENT health concerns: _____ Current

prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over the counter mediations (including vitamins, herbal remedies, etc.):

_____

_____

Allergies and/or adverse reactions to medication: ☐None
If yes, please list: _____

Substance Use History

Substance Type	Current Use (last 6 mos.)				Past Use			
	Y	N	Freq	Amount	Y	N	Freq	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/Crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
LSD								
PCP								
Steroids								
Benzodiazepines								

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Have you had withdrawal symptoms when trying to stop using any substances?
☐YES,☐NO If yes, please describe:

_____

_____

Have you ever had problems with work, relationships, health, the law, etc., due to your substance use? ☐YES ☐NO If yes, please describe:

_____

_____

Interpersonal/Social/Cultural Information

Please describe your social support network (check all that apply):
☐Family Neighbors Friends ☐Co-workers ☐Community Group

☐Religious/Spiritual Center

To which cultural or ethnic group do you belong? _____

How important are spiritual matters to you? ☐Not at all ☐Little

☐Somewhat ☐Very much

Describe any special areas of interest or hobbies:

_____

_____

_____

Additional Information

<u>Employment</u>
Employer:_____Position: _____
Stress level of this position: ☐Low ☐Medium ☐High

<u>Education</u>

Are you currently attending school? ☐Yes ☐No
☐High School Graduate? ☐GED Year_____
College Degree _____ Year _____ Major _____

<u>Military Service</u>

Have you been/are you currently in the military? ☐Yes ☐No
Branch_____Date of Discharge _____

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Type of Discharge_____ Rank _____

Were you in combat? ☐Yes ☐No

Legal

Are you currently involved in any open legal matters? Yes ☐ No ☐ If yes, please explain_____

Are you currently involved in any divorce or child custody proceedings? ☐Yes ☐No

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What gives you the most joy or pleasure in your life?

What are your most important hopes or dreams?

Additional Comments: